Alabama 1915(b) Independent Assessment Report

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Table of Contents

Glossary of Terms

This section provides a description of terms, proper names, acronyms, and phrases used throughout this report. The list is restricted to specific terms used in this report and Alabama Medicaid-specific terms.

Term / Acronym	Definition / Description / Application
1915(b)(1) Waiver	Alabama Managed Care Waiver. The Alabama 1915(b)(1) Waiver program is a Medicaid managed health care system for maternity and primary (PCCM) care services.
AMAES	Alabama Medicaid Application and Eligibility System – The computer system that maintains data files for all recipients.
Appeals	Activities and steps necessary to process a request for an appeal submitted by a provider or recipient that has been notified of a service contract deficiency.
Benefits	Activities and steps required to provide Medicaid providers or recipients with the information necessary to satisfy inquiries concerning Medicaid benefits for which the Medicaid recipient in question is entitled to.
Call Center Management	Processes, tasks, activities and steps necessary to maintain and manage the telephone hardware and software required to operate the Medicaid Call Center Services for Recipients and Providers.
Case Management	The process related to assessment, planning and advocacy for options and services for individuals with special health needs to promote cost effective outcomes. A medical service program operated by the Alabama Department of Public Health.
Case Manager	A specialized health care worker who is continuously responsible for managing the health care needs of assigned clients.
Centers for Medicare & Medicaid Services	The agency in the Department of Health and Human Services with responsibility for administering the Medicaid, Medicare, and State Children's Health Insurance programs at the federal level. Formerly known as the Health Care Financing Administration (HCFA).
CMS	Centers for Medicare & Medicaid Services

Term / Acronym	Definition / Description / Application
CMS-64	A federally mandated report (also known as the HCFA-64) produced by state Medicaid agencies to report Medicaid expenditures to the federal government providing the basis for the federal matching funds paid to Medicaid states.
COLD	Computer Output on Laser Disk
Contract Compliance	Tasks, activities and steps required to ensure compliance by vendors with the terms of the contractual agreements executed between the Medicaid program and the vendor.
Contract Management	Processes, tasks, activities and steps necessary to manage contractual agreements with vendors of services provided to the Medicaid program.
DHHS	The US Department of Health and Human Services
Documentation	Written and/or graphic material that describes organizational procedures and/or system processes.
Drug Utilization Review	Tasks associated with proactively monitoring and surveying program data to assure appropriateness of drug prescriptions.
DSS	Decision Support System: Software and database designed to help people at all levels of an organization make decisions.
EDS	Electronic Data Systems: The technology firm currently holding the Medicaid Fiscal Agent contract with the Alabama Medicaid Agency.
Eligibility	A process of determination, by Medicaid or an agency specified in the State Plan for Medical Assistance as a certifying agency through a written application, of eligibility for medical assistance. Fulfillment of requirements and meeting of qualifications to receive medical and/or social services.
Emergency Room Report	A utilization report run by the Alabama Medicaid Agency to review emergency room utilization by recipients, identify recipients with high utilization patterns, and provide feed back to the PMP.
Enrollee	A Medicaid Recipient who is currently enrolled in the Maternity Care Program via her district of residence or in the Patient 1st Program.
Enrollment	Used to describe the total number of enrollees in a health benefit program or health plan. It may also be used to refer to the process of enrolling people in a program or health plan.

Term / Acronym	Definition / Description / Application
EQR	External Quality Review: the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness and access to the health care services that an MCO or their contractors furnish to Medicaid recipients.
EQRO	External Quality Review Organization: an organization that meets the competence and independence requirements set forth in CFR 438.354, and performs external quality review, other EQR-related activities as set forth in CFR 438.358, or both.
ER	Emergency Room
Fair Hearings	Processes, tasks, activities and steps necessary to collect information required to initiate fair hearings procedures as requested by Medicaid recipients and required by the Medicaid grievance and appeals regulation and process.
Federally Qualified Health Center (FQHC)	A community health center or clinic that provides services to low-income people and meets federal qualifications for receipt of Medicaid payments.
Fee-for-Service	Payment to providers based on services performed rather than on the number of clients covered.
Fiscal Agent	An organization or corporation that contracts with a State to provide client outreach, provider outreach, training, claims processing, and other operations duties needed by the State to manage and administer the Medicaid program.
FourThought Group (4TG)	An independent contractor specializing in project management , quality assurance, contract management support, information system requirements engineering and architecture, procurement and implementation services for Medicaid Management Information Systems and other healthcare information systems.
Geographic information reporting	The tasks associated with gathering information, analyzing data, producing and distributing reports that deal with geographic information to support the Medicaid program.
Geographic Information System (GIS)	A system of computer software, hardware and data used to manipulate, analyze and present information that is tied to a spatial location.
Global Fee	A fee paid to a provider based on a negotiated basis between the provider and payer that encompasses a set of related or dependent health care services.
Grievance	A written statement of dissatisfaction submitted by an enrollee.

Term / Acronym	Definition / Description / Application
Grievances and Appeals Management	Processes, tasks, activities and steps necessary to collect information required to initiate grievance and appeals procedures as requested by Medicaid providers or recipients.
HEDIS Measures	Health Plan Employer Data Information Set Measures a nationally recognized set of standardized measures designed to compare the performance of managed care health plans developed by the National Committee for Quality Assurance (NCQA).
Information Management - Strategic Policy and Performance Management	Processes involved with the management of the Medicaid program. This includes activities to long range or strategic planning and processes such as policy development, Electronic Information Systems (EIS) reporting as well as activities involved with monitoring program compliance.
Letters	Tasks, activities and steps required to draft, produce and deliver letters to Medicaid providers or recipients.
Lock-in	A program that restricts selected Medicaid clients to services from particular physicians and/or pharmacists.
Managed Care Organization (MCO)	Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. The term generally includes HMOs, PPOs, and Point of Service plans. In the Medicaid world, other organizations may set up managed care programs to respond to Medicaid managed care. These organizations include Federally Qualified Health Centers, integrated delivery systems, and public health clinics.
Managed Care Quality Monitoring	Tasks associated with monitoring the quality provided by health plans and managed care organizations.
Mandatory Activities	Certain activities that must be done to produce data for EQR. CFR 438.358(b)
Maternity Care District	Geographic division(s) of the State of Alabama as defined by Medicaid to provide maternity care services to all women eligible for the maternity care program.
Maternity Care Primary Contractor	A person, or organization agreeing through a direct contract with the Alabama Medicaid Agency to provide those goods and services specified by contract in conformance with the requirements of the bid and Alabama Medicaid, state and federal laws and regulations.

Term / Acronym	Definition / Description / Application
Medicaid	The medical assistance program described in Title XIX of the federal Social Security Act. Each state administers a separate Medicaid Program that is financed by both federal matching funds and state funds and is subject to federal review.
Medicaid for Low Income Families (MLIF)	Eligibility criteria based upon poverty level and family size.
Optional Activities	Certain activities that are not required to produce data for EQR. CFR 438.358(c)
PCCM	Primary Care Case Management means a system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.
Performance Measure	Consistent measurements of service, practice, and governance of a health care organization.
Performance Measurement	The tasks associated with analyzing predefined performance measures established by the State to measure quality of care provided by managed care primary providers.
PMP	Primary Medical Provider means a family practitioner, general practitioner, internist, or pediatrician, an entity that provides or arranges for PMP coverage for services, consultation, or referrals 24 hours a day, seven days a week.
Prepaid Inpatient Health Plan (PIHP)	An entity that provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.
Primary Care	All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.
Profiler	A physician report card generated by the Alabama Medicaid Agency.
Provider	A person, organization, or institution enrolled with the Alabama Medicaid Agency that provides services to enrolled recipients.
Provider Credentialing	Tasks, activities and steps necessary to verify the legitimacy of the credentials submitted by providers applying to be enrolled in the Medicaid program to determine the eligibility of that provider to be a provider in the Medicaid program.
Provider Enrollment	Processes, tasks, activities and steps required to register a provider in the Medicaid program.

Term / Acronym	Definition / Description / Application
Provider Statistical Profiles	Activities associated with producing information comparing providers based on selected utilization review criteria such as delivery of care characteristics, costs, etc. Includes methods of comparative analysis across a group of peers (providers) by which standards for quality of care are developed and performance is measured.
Quality Assurance Plan	The Alabama Medicaid Agency requires Maternity Care Primary Provider contractors to submit a plan for quality assurance activities that will be administered to ensure the quality of the Medicaid Maternity Care Services that the contractor provides.
Quality Assurance (QA)	A process of analysis and review that endeavors to reduce errors and maintain quality for software, data, or procedures.
Quality Assurance Committee	A requirement of the Alabama Medicaid Agency Maternity Care Program (PIHP). The Primary Contractor's Quality Assurance Committee meets quarterly to review and discuss the evaluation of the programs enrollment process, grievance, internal and external QAPI activities, performance improvement projects, focused studies, and provider network issues. Meeting Minutes are sent to Medicaid QA Unit for review.
Quality Assurance Process Improvement	An objective and systematic process that evaluates the quality and appropriateness of care and service to members, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.
Recipient	An eligible person who receives services in a program administered by the Alabama Medicaid Agency. Also known as a beneficiary, client or member in the Medicaid managed care environment.
Recruiting	Processes, tasks, activities and steps necessary to recruit providers in to service with the Medicaid program as enrolled providers.
Recipient Explanation of Medicaid Benefits (REOMB)	A patient survey sent to a selected sample of Alabama Medicaid recipient's enrolled in the Managed Care Programs on a quarterly basis. There is a specific REOMB for Patient 1st and Maternity Care.
SOBRA	Sixth Omnibus Budget Reconciliation Act
Software Engineering Services (SES)	A process oriented, information technology services consulting agency, specializing in independent verification and validation services since 1992.
Specialty Certification	Activities and steps necessary to verify the professional specialty certifications of providers applying for enrollment in the Medicaid program.

Term / Acronym	Definition / Description / Application
Surveillance and Utilization Review (SURS)	The required MMIS subsystem that manages information related to post-payment review and quality assurance that is used to detect fraud, abuse, and inappropriate utilization or provision of services.
Surveys	Tasks associated with collecting data for a specified analytical purpose.
Temporary Assistance for Needy Families (TANF)	A temporary welfare program. The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) eliminated the AFDC program and replaced it with a block grant program for temporary assistance for needy families (TANF). This law also established a new Medicaid eligibility group for low income families (MLIF) with children. Under the law, receipt of TANF does not entitle the recipient to Medicaid.
Utilization Review	Prospective, concurrent and retrospective review and analysis of data related to utilization of health care resources in terms of cost effectiveness, efficiency, control, quality and medical necessity.

Section 1 Executive Summary

As part of the Alabama 1915(b) Medicaid Waiver renewal process, the Centers for Medicare and Medicaid Services (CMS) requires that an independent assessment of the Alabama Medicaid Agency programs operating under the waiver is conducted to determine whether programs are meeting the requirements outlined in the approved waiver document in terms of access to care and quality of services. Software Engineering Services (SES) has contracted with the Alabama Medicaid Agency to perform the Independent Assessment of the programs operating under the Agency's 1915(b) waiver, the Maternity Care and Patient 1st programs, and to conduct a survey of program recipients with technical assistance from the FourThought Group, Inc. (4TG). The Independent Assessment activities and findings identified for reporting under this contract include an assessment of internal Medicaid Agency operations and a recipient survey.

The purpose of the Alabama 1915(b) Independent Assessment Report is to report the findings of the Independent Assessment and determine whether the Medicaid programs implemented under the 1915(b) waiver program are meeting the requirements for access to care and quality of services outlined in the waiver documents approved by the CMS. The Report also makes recommendations noting areas in which the Medicaid Agency could make improvements in processes, procedures or documentation in order to better comply with the requirements of the waiver document.

1.1 Alabama Medicaid Managed Care Programs

Alabama Medicaid Managed Care Programs include the Patient 1st Program and the Maternity Care Program. The Patient 1st Program is a traditional primary care case management program in which patients are assigned a Primary Medical Provider (PMP). The PMP is responsible for either providing direct services or making appropriate referrals.

The Maternity Care Program provides services designed to ensure that every pregnant woman in Alabama has access to medical care. The State's counties are divided into 14 Maternity Care Districts. Each Primary Contractor is responsible for the implementation of maternity services following the Maternity Care Program guidelines.

1.2 Data Available for This Report

Data available for this report includes the responses of Medicaid Agency personnel to the questions in the interview tool developed by 4TG. This tool can be found in Section 3. Findings from the recipient survey will be included at a later date.

1.3 Analysis

An analysis of the Assessment and survey findings for the Patient 1st and Maternity Care programs was completed. The analysis period for the Patient 1st Program was December 1,

2004-May 31, 2006. The analysis period for the Maternity Care Program was August 1, 2005-May 31, 2006.

1.4 Independent Assessment

Independent assessment activities included the development of a tool listing required Core Competencies in four areas: Administration, Enrollee Access and Receipt of Program Services, Provider Network, and Enrollee Information. Interviews were conducted with key Medicaid personnel to review the Agency's processes and documentation to assess compliance with specific requirements of the Alabama 1915(b) waiver.

1.5 Recipient Survey

A recipient survey is being conducted of 1000 geographically distributed Patient 1st enrollees and 300 geographically distributed Maternity Care Program enrollees to determine their perception of the quality of and access to services under the respective programs. At the time of the writing of this report the method of administration of the survey and the content of the questions is in process. Final survey results will be added to this report at a later date.

1.6 Summary

This report presents the assessment purpose, scope, methods, findings and conclusions of the Independent Assessment of the 1915(b) waiver program and Recipient Survey as conducted for the Alabama Medicaid Agency from August 2006 through September 2006.

Section 2 Report Overview

2.1 Purpose

The purpose of this deliverable is to report the findings of activities engaged in by SES and 4TG in joint agreement for the purposes of performing an independent assessment for the Alabama Medicaid Agency to determine whether the Medicaid programs implemented under the 1915(b) waiver program are meeting the requirements for access to care and quality of services outlined in the CMS approved waiver document.

2.2 Scope

The Alabama 1915(b) Independent Assessment Report is a presentation of the techniques used and findings obtained by SES and 4TG during the Independent Assessment of the programs operating under the Alabama Medicaid Agency 1915(b) waiver for compliance with the CMS waiver requirements. The Independent Assessment examines Medicaid program compliance in the areas of Access to Care and Quality of Service in the four core competencies identified in the Alabama 1915(b) Waiver including: Administration, Enrollee Access and Receipt of Program Services, Provider Network and Enrollee Information. The report also covers the objectives, administration and findings of a survey of program recipients enrolled in the 1915(b) waiver programs that was developed and conducted by SES and 4TG for the Alabama Medicaid Agency. The 1915(b) programs included in the assessment are the Patient 1st Program Primary Care Case Management (PCCM) and the Maternity Care Program Prepaid Inpatient Health Plan (PIHP). The scope of the activities performed by SES and FourThought Group in the preparation of this report includes an assessment of compliance with specific requirements of the Alabama 1915(b) waiver through interviews with Alabama Medicaid Agency staff, identification of compliance documentation, and the development and administration of the recipient survey.

The Agency has contracted with Mark Carpenter, Ph.D., Director of Statistics, Associate Professor of Statistics, Department of Mathematics and Statistics, Auburn University to conduct the cost effectiveness requirements of the Independent Assessment. While much of the work that he is currently doing overlaps with the Independent Assessment requirements, the cost effectiveness requirements assessment are not within the scope of this report.

2.3 Description of Alabama Medicaid Managed Care Programs

2.3.1 Patient 1st Program

The Patient 1st Program was initially implemented in January 1, 1997. A traditional PCCM managed care program, Patient 1st Program recipients are assigned a Primary Medical Provider (PMP). It is reported that more than 1,300 primary care physicians and clinics serve as PMPs in the program. The PMP is responsible for either providing direct services or making

appropriate referrals. A PMP is paid a monthly case management fee in addition to fee for services reimbursement. The Medicaid program auto assigns a PMP to Medicaid recipients enrolled in the Patient 1st program with provisions for recipients to opt for a PMP of their choice if they are not satisfied with their Medicaid appointed provider.

The original Patient 1st program was operational from 1997 through February 2004 and was re-implemented with program enhancements beginning in December 1, 2004 with full implementation in February 1, 2005. The present program includes expanded technology and tools to help doctors and other health professionals better manage the increasing cost of health care while promoting improved quality of care for Medicaid recipients.

The goal of the program is to improve health care for Medicaid recipients by providing a medical home while containing the growing costs of providing quality health care. Medicaid-eligible individuals in certain categories are required to participate in the Patient 1st program. Exceptions may be made in certain circumstances, as in the case of a patient with a terminal illness or when a recipient has both Medicare and Medicaid coverage.

2.3.2 Maternity Care Program

The Alabama Medicaid Maternity Waiver program was implemented in 1988, under the authority granted by the Health Care Financing Administration (HCFA) for a 1915(b) waiver. The Balanced Budget Act of 1997 provided Medicaid with the authority to convert the Maternity Waiver to a State Plan based program. The program was converted to a State Plan option in 1999. In 2005 the Agency was required to apply for waiver authority.

The mission of the program is to provide services to achieve the best possible birth outcome for Medicaid recipients. The Alabama Medicaid Maternity Care Program is designed to ensure that every pregnant woman has access to medical care, with the goal of lowering Alabama's infant mortality rate and improving maternal and infant health. Medicaid recipients certified through the Sixth Omnibus Budget Reconciliation Act (SOBRA) Program, Medicaid for Low Income Family (MLIF) Program, Refugees and SSI eligible women are required to participate in the Maternity Care Program. The annual budget for the Maternity Care Program is approximately $120 million.

The Medicaid Agency has divided the States counties into 14 Maternity Care Districts. Each district is awarded by contract to a Primary Contractor under an ITB process. Each Primary Contractor is responsible for the implementation of a coordinated, comprehensive system of maternity services to provide for prenatal through delivery care under the Maternity Care Program guidelines. Program service components include: Case management, Medical Care, High Risk Pregnancies and a post-natal Home Visit with a focus on such issues as mental health, domestic violence and other special health care needs. Upon delivery, the Primary Contractor is paid a global fee for all components of care. The fee is a price negotiated during the bid process with the State.

2.4 Organization of Report

The Alabama 1915(b) Independent Assessment Report is organized in six sections containing sub-sections. The sections are:

- ☐ 1.0 Executive Summary - A brief statement of the purpose, activities, and findings contained in the report.
- ☐ 2.0 Report Overview – An overview of the purpose, scope, Medicaid programs assessed and organization of the report.
- ☐ 3.0 Assessment of Core Competencies – Presentation of the Independent Assessment findings organized by Core Competencies and Assessment area.
- ☐ 4.0 Recipient Survey Findings – Describes the survey development, administration and data findings.
- ☐ 5.0 Analysis – An analysis of the Assessment and survey findings for the Patient 1st and Maternity Care programs.
- ☐ 6.0 Conclusions and Recommendations
- ☐ Appendices - Includes list of Documents obtained during the compliance assessment and the recipient survey instrument.

Section 3 Independent Assessment of Core Competencies

3.1 Patient 1st Program

3.1.1 Core Competency: Administration

Assessment Area	**Quality of Service**
1.	**Describe strategies and accomplishments achieved in meeting program goals and performance outcome.**
Documentation:	▪ *Alabama Medicaid Agency Overall Quality Assurance Plan* o *Quality Assurance Strategy* o *Quality Assurance Unit Policies and Procedures* ▪ *Medicaid Program Provider Manual Chapter 39* ▪ *PMP Contracts* ▪ *REOMB Survey* ▪ *Patient 1st Quality Assurance Memorandum to the Alabama Medicaid Agency Commissioner*

Summary of Findings:

The Alabama Medicaid Agency strategies and accomplishments for performance outcomes are defined in the Agency Quality Assurance Strategy for the Medicaid Program. The Quality Assurance (QA) Unit is responsible for implementation of the Quality Strategy. Functions of the QA Unit include:

- *Review and Oversight of Complaints and Grievances*
- *Utilization Review*
- *Implementation of the REOMB Recipient Survey Tool*

Measurement of progress toward program goals and performance outcomes for the Patient 1st program occurs through utilization review activities, PMP change rates, PMP contract compliance monitoring, follow-up on complaints and grievances, and REOMB surveys.

The utilization review for Patient 1st focuses on two service areas: Emergency Room (ER) visits and Pharmacy. These areas have been identified by the Medicaid program as the services in which the greatest impact could be made in terms of improving access to care, quality of services and cost efficiency through utilization review and follow-up activities.

ER Utilization Review examines inappropriate use of the emergency room. DSS is used to pull information on emergency room visits. The basis for counting the service is the use of procedure codes 99281-99285. All costs associated with the visit are reflected. Report elements are the patient's name, Medicaid number, PMP on date of service, procedure code, certified emergency indicator, diagnosis, total amount paid, date of service, hospital provider and hospital provider number. The Medicaid Agency QA unit is responsible for the summary and detail reports. The summary report of ER utilization is sent on a quarterly basis to PMPs. The Agency sorts on three levels and if it is found that a PMP is not meeting the contractual obligation, then the case management fee will be reduced accordingly.

Pharmacy reviews are conducted with pharmacy claims and recipients with high or duplicative usage are investigated. Provider record reviews may be conducted and recipients with unexplained over utilization or misuse of pharmacy services are identified for program "Lock-In." Recipients assigned to "Lock-in" are limited to services from a single provider and pharmacy to more effectively manage utilization.

Implementation of utilization review with a focus on ER and Pharmacy has resulted in improved coordination and communication with Providers, improved coordination of care, more efficient and effective utilization of services, improved disease management and outcomes, and improved cost efficiency.

Several processes are used to monitor program goals and performance outcomes. Focus areas include the enrollee assignment process, patient dismissals and patient change rates. For each of these there is a specific report which generates information regarding these issues.

The enrollee assignment report details the most appropriate care giver is assigned based on patient's choice, family linkage and/or historical patterns of care. Any problems identified will be referred to EDS for system monitoring.

Dismissals are monitored to ensure that patients are being dismissed by PMPs for "just cause" and the recipient is being notified appropriately. If discrepancies are noted, the PMP is contacted and educated regarding Patient 1st dismissal policy.

A patient change rate report indicates patients that have changed PMPs more than three times within a six month period. Potential aberrant behavior will be referred to case management for appropriate interventions and education.

The REOMB "Recipient Explanation of Medicaid Benefits" survey of recipients is conducted monthly to assess recipient satisfaction with PMP and Patient 1st Program. REOMB surveys may be conducted in response to complaints and grievances. REOMBS are requested monthly based on previous 9 months billing 250 per county per year is sent based on a monthly schedule. When received, results are tabulated and a written report and graph generated. The REOMBS/Recipient Survey Report consists of a computer generated graph for each question contained in the survey. The REOMBS/Recipient Survey Report results are calculated and reported quarterly. Trends and patterns will be monitored to be reported and referred as necessary.

The Medicaid program is in the process of finalizing a profiling system within the DSS known as "Profiler" to perform provider statistical profiling analysis by comparing such measures as provider patterns of service provision and prescribing patterns with those of their peers. A panel of peers for comparison is selected based on enrollment criteria and the system performs comparative analysis against that panel based on selected reporting parameters. The system will be used to develop physician-driven performance measures and monitor progress toward achieving program performance goals. The profile parameters selected for implementation are "non-certified" ER, Pharmacy and office visits per unique member.

Assessment Area	**Quality of Service**
2.	**Describe the use and the effectiveness of the provider profiles in monitoring the achievement of program goals and objectiveness.**
Documentation:	▪ *PMP Contracts* ▪ *Patient 1st Quality Assurance Memorandum to the Alabama Medicaid Agency Commissioner*

Summary of Findings:

The "Profiler" that is currently in development for the DSS with EDS will be used to perform provider profiling

and monitoring of achievements toward program goals and objectives for cost effectiveness, quality of services and access to care through peer comparisons. The State is in the process of developing goals and objectives for new reporting protocols for the "Profiler." The profiler will be used to establish performance measures that will adapt to changes in the services and provider environment over time laying the foundation for future use of a Pay-for-Performance payment system for Medicaid providers. Because the Agency is committed to share savings with the providers, initially, providers will be rewarded or given a bonus check, known as "Performance Checks." This payment is based on how well they are performing within contract and program quality guidelines as compared to their peers.

Assessment Area	**Quality of Service**
3.	**Describe procedures for monitoring providers and the results used to determine whether Primary Medical Providers (PMP) meet the terms and conditions and performance agreements of the written contract with the Agency.**
Documentation:	▪ *PMP Contracts* ▪ *Patient 1st Quality Assurance Memorandum to the Alabama Medicaid Agency Commissioner*

Summary of Findings:

Currently, PMP monitoring is conducted through contract monitoring activities performed by the Patient 1st program and QA Units. The contract monitoring policies and sanctions for non-compliance with the terms and conditions and performance agreements of the written contract with the Agency are included in the PMP Contracts for Primary Medical Providers (PMP). This includes monitoring 24 hour availability. Follow-up of complaints and grievances, response to claims and utilization review, contract compliance audits such as random 24 hour access monitoring or call-center reporting may trigger a provider review by the Agency.

To ensure that PMPs are meeting the requirement for providing 24/7 coverage. A random 25% sample of PMPs will be pulled based on the after-hours information contained on the managed care provider screen. At least 75% of the PMPs chosen must indicate an arrangement other than the local emergency room. Report elements will be PMPs name, office phone number, 24/7 phone number and address. A DSS Query will be pulled indicating the PMPs. A phone call will be placed after regular office hours to assess what system is in place to provide 24/7 coverage. The information gathered will then be compared to the PMPs application. A report will be generated breaking down the sample results by system used. Any provider found to be out of compliance with his/her application will be referred to Program staff for follow-up. If a PMP is being paid a case management fee for after-hours coverage, but through the random review is found not to be adhering to the contract requirements, the case management fee will be reduced accordingly. A letter will be sent to the PMP via certified mail indicating the finding and offering a 30 day grace period for correction. If the deficiency is not corrected, the case management fee will be reduced with the next scheduled update.

"Info-Solutions," a software program of Blue Cross/Blue Shield has been implemented for use by the Medicaid program which allows the physicians access to pharmacy utilization data for improved patient management.

The Medicaid Agency is developing procedures to use the Profiler for the purposes of monitoring provider contract compliance as soon as it is available. The Profiler system still in development will monitor a rolling year of claims information because claims have a 5 month lag time to accommodate claims filing. Standards for system monitoring of contract and performance agreements are in development.

Assessment Area	**Quality of Service**

4.	**Describe procedures used to ensure that a smooth, undisrupted placement / transition occurs for enrollees when the "primary care" provider dis-enrolls from the program or changes practice location.**
Documentation:	▪ *Alabama Administrative Code Chapter 37* ▪ *Medicaid Program Provider Manual Chapter 39* ▪ *New Enrollee Packet and Recipient Handbook* ▪ *H550 Report* ▪ *H990 Report*

Summary of Findings:

The Alabama Administrative code mandates a smooth, undisrupted placement and transition for enrollees when the PMP dis-enrolls or changes location. If the PMP, changes location or practice, the PMP has the option of taking the recipients assigned to him/her if the change is local. If the PMP is in a group practice and leaves without taking the assignees with them, then the enrollees are reassigned to a provider within that group. If the PMP dis-enrolls from the Patient 1st program or moves out of the area the Medicaid program takes action to re-assign enrollees as soon as they are notified of the dis-enrollment or of the relocation. When the Patient 1st program becomes aware of the need for reassignment, an H550 report is run in the eligibility system to re-assign all enrollees in the report. The morning following the generation of the H550, an H590 is run to check the accuracy of the H550 identifying any recipients that were not reassigned. Notification of reassignment is sent to recipients as soon as reassignment is made. The notification explains the enrollee rights to change providers and the procedures for doing so.

Medicaid recipients may change their PMP at any time regardless of reassignment, so if they are not satisfied with the reassignment they may request a change of PMP. Changes that are made before the 15th of the month will be effective on the first day of the month after the change is made. Changes made after the 15th of the month will become effective the first day of the second month after the change is made.

Information concerning change of PMP is available to recipients in the Recipient Handbook and on the Alabama Medicaid Agency website. The website also offers the tools to make needed changes. Dis-enrollment procedures for providers are explained in the provider contracts and operations manual.

Assessment Area	**Access to Care**
5.	**Describe how "enrollee services date" as addressed in the Patient 1st contract is used as a way to analyze whether a provider is within the Patient 1st comparison parameter.**
Documentation:	▪ *PMP Contract* ▪ *Medicaid Program Provider Manual Chapter 39*

Summary of Findings:

It is the responsibility of the State to gather and analyze data relating to service utilization by enrollees to determine whether PMP's are within acceptable Patient 1st comparison parameters. The provider is required by the PMP contract to review and use all enrollee utilization and cost reports provided by the Patient 1st Program for the purpose of practice level utilization management and advise the Agency of errors, omissions, or discrepancies and to review and use the monthly enrollment report as required by Patient 1st policy. The Medicaid Program Provider Manual, Chapter 39 speaks to how often reports are pulled and utilized.

Assessment Area	Access to Care
6.	Describe the "ongoing quality assurance program" and how this procedure is used to evaluate the quality of health care services to enrollees.
Documentation:	▪ *Alabama Medicaid Agency Overall Quality Assurance Plan* o *Quality Assurance Strategy* o *Quality Assurance Unit Policies and Procedures* ▪ *Medicaid Program Provider Manual Chapter 39* ▪ *PMP Contracts* ▪ *REOMB Survey* ▪ *QA Stakeholder meeting agendas and minutes* ▪ *Patient 1st Quality Assurance Memorandum to the Alabama Medicaid Agency Commissioner*

Summary of Findings:

The Patient 1st program staff and QA unit of the Medicaid Agency work in tandem with all stakeholders to ensure a practice of ongoing quality assurance. The QA unit is responsible for such ongoing activities as REOMB surveys described in Question 1, monitoring and following up on complaints and grievances, claims and utilization review while the Patient 1st program staff conduct ongoing activities related to contract compliance including random audits of 24 hour accessibility.

In addition to program quality assurance activities, monthly to quarterly meetings are held with Patient 1st program staff, QA and other stakeholders in the QA strategy such as EDS, the Agency Provider Outreach and Education unit to review various findings and identify issues for follow-up. This is a formalized way to share information such as Agency units reporting problems, grievances, call center issues, etc. There is a standing agenda and formal minutes are taken at these meetings and a process is in place for follow up implementation to address problems identified in the meeting. Use of the "Profiler" reports will become part of the ongoing reviews as data is available.

3.1.2 Core Competency: Enrollee Access and Receipt of Program Services

Assessment Area	Access to Care
7.	Describe procedures or strategies used to monitor/ensure timely access of covered services for new and existing enrollees.
Documentation:	

Summary of Findings:

The Medicaid Agency does not monitor covered services beyond complaints and grievances for denied services. If issues regarding access to covered services are identified the case is investigated. The Patient 1st program requires coverage of a second opinion if requested by the recipient and PMP specialty referrals.

Assessment Area	Access to Care
8.	Describe procedures utilized to ensure providers geographic accessibility for enrollees, especially in rural and remote areas of the State.
Documentation:	▪ *DSS reports are available* ▪ *COLD reports are available*

Summary of Findings:

The Patient 1st program reviews DSS reports of numbers of providers by county of residence and the ratio of providers to the number of enrolled recipients by county. Physicians can enroll to provide services in their own county or other counties in the surrounding area. A report is run by county that contains number of providers serving that county and an analysis of providers serving by county and number of recipients. A PMP is permitted to have up to 1200 on their panel, for each physician extender, e.g., nurse practitioner, an additional 400 patients can be allowed. The maximum case load is 2000 enrollees. Because the majority of recipients in Patient 1st are children, the program has more general provider types enrolled.

Assessment Area	Quality of Service
9.	Describe procedures utilized to follow-up on problems or issues brought to the State's attention by program enrollees or as a result of program monitoring or evaluations.
Documentation:	▪ *Alabama Administrative Code Chapter 37* ▪ *Medicaid Program Provider Manual Chapter 39* ▪ *New Enrollee Packet and Recipient Handbook*

Summary of Findings:

The Patient 1st program follows the formal complaint and grievance process required by State Administrative Code and established in the Operations, Recipient and Provider Manuals. Complaint and grievance logs are continually monitored and follow-up is conducted with providers and recipients as the nature of a complaint warrants. Informal complaints may be made outside of the grievance process directly to program personnel who will follow-up on the complaint immediately. If informal complaints are not resolved at that time the grievance process may be engaged.

Complaint and grievance logs are maintained and reviewed. If the result of a complaint or grievances, or if non-compliance with PMP contract terms is identified through monitoring activities and a corrective action is needed, like a program hearing, the PMP would be notified and required to submit a corrective action plan.

The QA unit documents the audit process logs and non–compliance notices and corrective action requests, and follow-up for compliance. Ongoing compliance auditing, utilization review and complaints and grievances alert QA staff to providers that may require ongoing observation or monitoring.

Assessment Area	Access to Care
10.	Describe procedures and monitoring results associated with enrollee wait time or hold time for telephone appointments, for provider services, referrals and for subsequent appointments.

Documentation:	▪ *Operations Manual* ▪ *Medicaid Program Provider Manual Chapter 39* ▪ *PMP Contracts* ▪ *REOMB Surveys*
Summary of Findings: Monthly random audits of PMP hold and wait times are monitored by Program Area staff on a periodic basis according to a geographic schedule. REOMB surveys are requested and reviewed by the QA unit and complaint logs may be monitored for issues related to wait and hold times and follow-up for corrective action is initiated.	
Assessment Area	**Access to Care**
11.	**Describe procedures and monitoring results of providers substantiating that enrollees have 24 hour access to their primary care providers. This should include monitoring results for providers maintaining specified weekly office hours.**
Documentation:	▪ *Alabama Administrative Code Chapter 37* ▪ *PMP Contracts* ▪ *Medicaid Program Provider Manual Chapter 39* ▪ *Patient 1st Quality Assurance* ▪ *Memorandum to the Alabama Medicaid Agency Commissioner* ▪ *Geographic 24 Hour Audit Schedule*
Summary of Findings: Providers statewide are randomly monitored for compliance with 24 Hour Access requirements contained in provider contracts and Alabama Administrative Code. The state is divided into geographic regions consisting of groups of counties and providers are randomly selected from the provider list according to a monthly rotating geographic schedule. The Patient 1st program area makes calls for information to PMP's after hours, weekends, and holidays, and if the information received is not in compliance with the 24 hour policy, the provider is notified in a letter of the audit findings and corrective action is requested. The 24 hour audit process is documented in the QA process outline provided to the Alabama Medicaid Agency Commissioner. The providers are informed in the PMP contract that monitoring activities will be conducted with regard to 24 hour access. The Agency does not have a formal method for monitoring weekly office hours. Because providers are contacted for various reasons throughout the day by program staff and enrollees, if a pattern of unavailability is detected, an inquiry will be made by mail. Based on the response, corrective action may be requested.	
Assessment Area	**Access to Care**
12.	**Describe procedures used to ensure that: a.) new enrollees are assigned to primary care providers within required timeframe; b.) enrollees are provided appropriate written information, within reading proficiency levels, for all program services; c.) non-English speaking enrollees have written information**

	appropriate for their nationality or language, and d.) enrollees have the ability to choose their own provider or change their primary care provider without penalties.
Documentation:	▪ *Alabama Administrative Code Chapter 37* ▪ *Recipient Handbook* ▪ *Medicaid Program Provider Manual Chapter 39*

Summary of Findings:

a) New enrollees are auto assigned to a PMP within 45 days of enrollment. Parents of newborns are provided with a form to mail in and new enrollees receive instructions for selecting a PMP in the enrollment notification. Procedures for PMP selection include mailing in the selection or making selections using the Medicaid website. When the Patient 1st program receives the notification of provider selection from the Enrollee, the information is entered into the Alabama Medicaid Application and Eligibility System (AMAES) and assignment is made on the 1st of the next month if the notification is received by the 15th of the month. If notification is received after the 15th of the month, assignment is made the 1st of the following month. Notification of assignment is sent to the Enrollee when the assignment is made in the system with information on how to contact the PMP.

b) The Alabama Administrative Code requires that written information meet CMS requirements for ease of understanding. All written materials meet the State standards. The Alabama Medicaid Agency Research and Development and Outreach and Education units are charged with developing reading level appropriate materials. The materials contained on the Medicaid website mirror those published and maintained by the Agency. The general rule of thumb is that the reading proficiency level must be at a 6th grade reading level for materials related to accessibility and at a Junior High level for all other recipient materials including the website. The State also utilizes techniques for improved readability such as use of white space to improve access and comprehension. The recipient handbook was recently revised lowering the reading level.

c) The Alabama Administrative Code requires written information because the state must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan, the State must:

- *Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the state.*
- *Prevalent means a non-English language spoken by a significant number of potential enrollees and enrollees in the state.*
- *The state and each managed care entity must make available written information in the prevalent non-English languages.*
- *Notify enrollees and potential enrollees and require each managed care entity to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages.*

The Medicaid website is a reflection of the notices and publications of the Agency. English and Spanish versions of the covered services book are available as well as the applications for enrollment. The Spanish and English materials are available in hard copy and soft copy on the website.
The website navigation is available in English only. The Agency has not received complaints concerning difficulties with website accessibility due to language.

Providers are required to provide oral interpretation services under contractual requirements for accessibility, and cost of interpreters is the responsibility of the provider.

The majority of the Agency's business with recipients is conducted by mail and the Agency does not capture any information about their languages or speaking abilities. The Call Center offers language accessibility

options and calls to the program directly are offered limited language accessibility as well. d) Included in the operation manual and materials given in the rights and duties.	
Assessment Area	**Quality of Service**
13.	**Describe procedures to monitor direct and coordinated care services by primary care providers. This should include arranging for and providing follow-up referral services.**
Documentation:	
Summary of Findings: Direct and coordinated care services by primary care providers are not monitored by the Medicaid Agency.	
Assessment Area	**Access to Care**
14.	**Describe corrective action to remedy barriers associated with access to services.**
Documentation:	
Summary of Findings: Alabama 1915(b) programs are not a traditional managed care program in which services must be authorized for payment. The Agency monitors recipients with regard to their access to services and provides avenues to voice complaints. Corrective action is taken when cases of obstruction to access are identified. Referrals are required of PMP's and the program does not penalize PMP for too many referrals.	

3.1.3 Core Competency: Provider Network

Assessment Area	**Access to Care**
15.	**Describe procedures for monitoring or ensuring acceptable provider-enrollment ratios.**
Documentation:	▪ *DSS Reports*

Summary of Findings:

The DSS provides reports concerning provider to enrollment ratios geographically. EDS processes provider enrollment and credentialing for all Medicaid providers. If a provider is eligible for Medicaid they are eligible for the Patient 1st program, if they are willing. In areas in which provider enrollment ratios may be low, generally providers may be low. If shortfalls occur, geographic availability boundaries may be adjusted.

Assessment Area	**Access to Care**
16.	**Describe procedures and outcome results used to monitor or to provide assurances that the total number of primary care providers and specialty providers equal or exceed the total number of providers enrolled in the previous Patient 1st waiver. Describe or provide a comparison of the specialists participating in the Patient 1st program with that of the total number of certified specialists in the State by specialty category.**
Documentation:	

Summary of Findings:

Services provided by specialists who have received referral from PMP's are paid as Fee-for-Service Claims.

The program does not have a specialty network and analysis of specialty ratios to state specialty totals by specialty have not been done.

3.1.4 Core Competency: Enrollee Information

Assessment Area	**Access to Care**
17.	**Describe the process used and the results indicating that enrollees' rights are protected and the appeal process is appropriately followed.**
Documentation:	▪ *REOMB Surveys* ▪ *Complaint and Grievance Logs*

Summary of Findings:

Enrollee rights violations are tracked through the complaints and grievances process.
The REOMB does address issues of perceived rights violations. The response rate is about 30% for the REOMB's.

The Quality Assurance Unit of the Medicaid Agency monitors Grievance and Appeals logs for compliance with the requirements of the Grievance and Appeals process established in the Operations Manual. If the logs reveal non-compliance with the process, cases are investigated, corrective action plans are requested and the process is followed to resolution.

Assessment Area	Access to Care
18.	Describe the process used to monitor established procedures and assurances for enrollee grievances being resolved.
Documentation:	▪ *Medicaid Program Provider Manual Chapter 39*

Summary of Findings:

The Quality Assurance Unit of the Medicaid Agency monitors Grievance and Appeals activities for compliance with the requirements of the Grievance and Appeals process established in the Operations Manual. All grievances and appeals cases are followed to resolution.

3.2 Maternity Care Program

3.2.1 Core Competency: Administration

Assessment Area	Quality of Service
1.	Describe strategies and accomplishments achieved in meeting program goals and performance outcome.
Documentation:	▪ *Alabama Medicaid Agency Overall Quality Assurance Plan* o *Quality Assurance Strategy* o *Quality Assurance Unit Policies and Procedures* ▪ *Maternity Care Operations Manual* ▪ *PMP Contracts* ▪ *QAPI Plans* ▪ *QAPI committee Minutes* ▪ *Performance Measure Summaries* ▪ *Focused Study Results and Summaries*

Summary of Findings:

As required by Alabama Administrative Code, the regular monitoring of the Maternity Care Program is essential to ensure that State requirements of the Maternity Care Program are met and quality maternity care is provided to every recipient participating in the program. A combination of efforts will be undertaken to monitor all aspects of the program with the primary focus on good patient outcomes and program improvement.

The Quality Assurance monitoring and review process is an ongoing assessment that will strive to promote quality initiatives and improvements. Initial monitoring areas may be revised and/or updated as necessary to reflect quality concerns in the changing Maternity Care environment.

Monitoring is an essential process for utilization management while determining unique performance awareness, patterns and oversight. Patterns of excellent, adequate or poor performance may indicate issues that need to be addressed at the District level or issues that affect the whole state. The Maternity Care QA Program will monitor Maternity Care activities on an ongoing basis. Aggregate data will be collected and compiled into periodic reports.

Interpretation of review findings will be reported through numerical spreadsheets and/or narrative summary. Further review and/or a request for a corrective action plan may be necessary dependent on review findings. Monitoring will require at a minimum:

- *Review of recipient medical records*
- *Review of Recipient Explanation of Medicaid Benefits (REOMBs)*
- *Review of Grievance Log*
- *Review of QI Tracking Log*
- *Review of QA Committee Meeting Minutes*
- *Review of Focused Studies*
- *Review of Performance Improvement Projects*

The REOMB "Recipient Explanation of Medicaid Benefits" survey of recipients is conducted monthly as a function claims review to ensure that patients are receiving the services that the Medicaid program is being billed. Inconsistencies between claims and survey results are investigated. REOMB surveys may be conducted in response to complaints and grievances.
To ensure the delivery of quality healthcare by all Districts, the input from the recipients must be considered. This will be accomplished by sending REOMBS/Recipient Surveys to recipients who have delivered within a certain timeframe throughout the year. REOMBS/Recipient Surveys are requested through Electronic Data Systems (EDS) and are chosen on a random basis according to county of residence and payment of procedure codes 59400, 59410, 59510, 59515. Every District is sampled every month. The number of surveys sent per District is based on the previous year's total number of deliveries in each District. The sample size is chosen every month based on delivery dates within one (1) month period that is (3) month prior to the requesting month. A list is updated each year reflecting the number of surveys to be requested. All completed REOMBS/Recipient Surveys are returned back to the Medicaid QA Division and grouped per District. The REOMBS/Recipient Survey Report consists of a computer generated graph for each question contained in the survey. The REOMBS/Recipient Survey Report results are calculated and reported quarterly.

Assessment Area	**Quality of Service**
2.	**Describe the use and the effectiveness of the provider profiles in monitoring the achievement of program goals and objectiveness.**
Documentation:	

Summary of Findings:

There is no provider profiling conducted by the Medicaid Agency in the Maternity Care program. Some of the Health Plans serving the Maternity Care program have developed a provider report card based on their ability to develop provider profiles. Most of the state level monitoring of individual providers in the Maternity Care program is achieved through medical record reviews and complaints and grievances.

Because of global fee payment arrangements with the Maternity Care Health Plans, the Medicaid Agency does not receive claims or encounter data.

Assessment Area	**Quality of Service**
3.	**Describe procedures used to ensure that a smooth, undisrupted placement / transition occurs for enrollees when the "primary care" provider dis-enrollees from the program or changes practice location.**

Documentation:	▪ *Alabama Administrative Code Chapter 37* ▪ *Maternity Care Operations Manual* ▪ *Primary Provider Contracts*

Summary of Findings:

Primary Contractors with the Maternity Care program are required by contract, and guidelines in the program operations manual, to establish procedures that ensure the smooth, undisrupted placement and transition of enrollees to a new provider when a provider dis-enrolls or relocates.

Assessment Area	**Access to Care**
4.	**Describe the "ongoing quality assurance program" and how this procedure is used to evaluate the quality of health care services to enrollees.**
Documentation:	▪ *Alabama Medicaid Agency Overall Quality Assurance Plan* o *Quality Assurance Strategy* o *Quality Assurance Unit Policies and Procedures* ▪ *Maternity Care Operations Manual* ▪ *PMP Contracts* ▪ *QAPI Plans* ▪ *QAPI committee Minutes* ▪ *Performance Measure Summaries* ▪ *Focused Study Results and Summaries*

Summary of Findings:

The ongoing Quality Assurance Program for the Maternity Care Program is defined in Question 1 of this section. QAPI plans, progress toward achievement of performance measures, and analysis of the results of focused studies will be used to develop strategies for performance improvement and improved patient care.

3.2.2 Core Competency: Enrollee Access and Receipt of Program Services

Assessment Area	**Access to Care**
5.	**Describe procedures or strategies used to monitor/ensure timely access of covered services for new and existing enrollees.**
Documentation:	▪ *Complaint and Grievance logs*

Summary of Findings:

Primary Contractors are required to provide covered services and monitor access to covered services by enrollees. Access to covered services is monitored by the Medicaid Agency by the QA Unit through monitoring of complaint and grievance logs. Complaints or grievances are followed by the QA unit to resolution.

Assessment Area	Access to Care
6.	Describe procedures utilized to ensure providers geographic accessibility for enrollees, especially in rural and remote areas of the State.
Documentation:	▪ *Primary Provider Contracts* ▪ *Complaint and Grievance logs* ▪ *Maternity Care Operations Manual*

Summary of Findings:

Geographic accessibility requirements within the Maternity Care program are managed and guaranteed by the Primary Contractors through their contracts with the program. Accessibility is an issue because of the specialized services of the program. In rural and remote areas of the state there are fewer providers, however, most providers in those areas do accept Medicaid. At the time of contract award, the Maternity Care contractors must demonstrate that their provider networks provide sufficient access to care for all recipients in their district. The access parameters under the Maternity Care contracts require a provider within 50 miles, or 50 minutes. Annual audits by the Maternity Care Program that include a review contracts supported by medical record reviews, and complaint and grievance monitoring have not revealed a failure on the part of any contractor to comply with this requirement.

Assessment Area	Quality of Service
7.	Describe procedures utilized to follow-up on problems or issues brought to the State's attention by program enrollees or as a result of program monitoring or evaluations.
Documentation:	▪ *Maternity Care Operations Manual* ▪ *Complaint and Grievance logs*

Summary of Findings:

Maternity Care provider monitoring is conducted by the contracting Districts. The State monitors Complaint and Grievance logs for compliance with formal Grievance and Appeals procedures. If it is identified that a Primary Contractor has not complied with the Grievance and Appeals process, the State will intervene by requesting corrective action and following up until the issue reaches resolution.

Assessment Area	Access to Care
8.	Describe procedures and monitoring results associated with enrollee wait time or hold time for telephone appointments, for provider services, referrals and for subsequent appointments.
Documentation:	▪ *Primary Provider Contracts* ▪ *Complaint and Grievance logs* ▪ *Maternity Care Operations Manual*

Summary of Findings:

These standards are established in the Maternity Care Operations manual. The contractors are required to monitor compliance with these standards in their networks. Annual audits by the QA staff review the

monitoring logs and corrective action issuances.	
Assessment Area	**Access to Care**
9.	**Describe procedures and monitoring results of providers substantiating that enrollees have 24 hour access to their primary care providers. This should include monitoring results for providers maintaining specified weekly office hours.**
Documentation:	▪ *Primary Provider Contracts* ▪ *Complaint and Grievance logs* ▪ *Maternity Care Operations Manual*
Summary of Findings: 24 hour access standards are established in the Maternity Care Operations manual and Primary Contractor District contracts. The contracting Districts are required to monitor compliance with these standards within their networks. Annual audits by the QA staff review the monitoring logs and corrective action issuances.	
Assessment Area	**Access to Care**
10.	**Describe procedures used to ensure that:** **a.) new enrollees are assigned to primary care providers within required timeframe;** **b.) enrollees are provided appropriate written information, within reading proficiency levels, for all program services;** **c.) non-English speaking enrollees have written information appropriate for their nationality or language, and** **d.) enrollees have the ability to choose their own provider or change their primary care provider without penalties.**
Documentation:	▪ *Alabama Administrative Code Chapter 37* ▪ *Maternity Care Operations Manual* ▪ *Provider Manual*
Summary of Findings: a) Timeframes for provider assignment for Maternity Care Enrollees are established in the Primary Contractor Contracts with the Maternity Care Program and program Operations Manual. Primary Contractors are responsible for enrollee assignment within the program guidelines. Compliance with these procedures is monitored through complaint and grievance monitoring. b) The Primary Contractors develop all recipient materials used in their district and materials are submitted for approval to the Maternity Care program. The Maternity Care program requires Primary Contractors and participating providers meet language proficiency levels when developing materials in compliance with	

Alabama Administrative Code.

c) The Primary Contractors develop all recipient materials used in their district and materials are submitted for approval to the Maternity Care program. The Maternity Care program requires Primary Contractors and participating providers have translated materials and provide oral interpreters in compliance with Alabama Administrative Code.

d.) The Primary Contractors participating in the Maternity Care plan are required to permit enrollees to freely choose or change providers without penalties under the contract provisions with the State. Compliance with these procedures is monitored through complaint and grievance monitoring.

Assessment Area	**Quality of Service**
11.	**Describe procedures to monitor direct and coordinated care services by primary care providers. This should include arranging for and providing follow-up referral services.**
Documentation:	

Summary of Findings:

Direct and coordinated care services by primary care providers are not monitored by the Medicaid Agency.

Assessment Area	**Access to Care**
12.	**Describe corrective action to remedy barriers associated with access to services.**
Documentation:	▪ *Primary Provider Contracts* ▪ *Complaint and Grievance logs* ▪ *Maternity Care Operations Manual*

Summary of Findings:

The Medicaid Agency QA staff monitors grievance and appeals logs and follows up to ensure corrective action plans are resolved.

3.2.3 Core Competency: Provider Network

Assessment Area	**Access to Care**
13.	**Describe procedures for monitoring or ensuring acceptable provider-enrollment ratios.**
Documentation:	▪ *Maternity Care Operations Manual* ▪ *Primary Provider Contracts*

Summary of Findings:

The Maternity Care program documents required provider-enrollment ratios in the program operational manual. The Maternity Care Primary Contractors are required to monitor provider accessibility and provider to recipient ratios. Primary Contractors are required by contract to demonstrate 50 mile/50 minute access for all women in their District. Primary Contractors provide the Maternity Care program with provider network information and any changes must be reported immediately. Providers to recipient ratios are monitored by the program as well.

3.2.4 Core Competency: Enrollee Information

Assessment Area	Access to Care
14.	**Describe the process used and the results indicating that enrollees' rights are protected and the appeal process is appropriately followed.**
Documentation:	▪ *Alabama Administrative Code Chapter 37* ▪ *Operations Manual* ▪ *Provider Contracts* ▪ *Primary Provider New Enrollee Packets and Recipient Manuals* ▪ *Grievance and Appeals Logs*

Summary of Findings:

The Primary Contractors contracting with the Maternity Care program are responsible under their contracts for providing enrollees with a statement of their rights and duties as required by Alabama Administrative code, monitoring compliance with protection of enrollee rights and managing the grievance and appeals process for enrollees. The Quality Assurance Unit of the Medicaid Agency monitors Grievance and Appeals logs for compliance with the requirements of the Grievance and Appeals process established in the Operations Manual. If the logs reveal non-compliance with the process, cases are investigated, corrective action plans are requested and the process is followed to resolution.

Assessment Area	Access to Care
15.	**Describe the process used to monitor established procedures and assurances for enrollee grievances being resolved.**
Documentation:	▪ *Alabama Administrative Code Chapter 37* ▪ *Operations Manual* ▪ *Provider Contracts* ▪ *Primary Provider New Enrollee Packets and Recipient Manuals*

Summary of Findings:

The Primary Contractors contracting with the Maternity Care program are responsible under their contracts for managing the grievance and appeals process for enrollees. The Quality Assurance Unit of the Medicaid Agency monitors Grievance and Appeals logs for compliance with the requirements of the Grievance and Appeals process established in the Operations Manual. If the logs reveal non-compliance with the process, cases are investigated, corrective action plans are requested and the process is followed to resolution.

Section 4 Recipient Survey Findings

4.1 Recipient Objectives

4.2 Technical Methods of Data Collection and Analysis

4.3 Description of Data Obtained

4.4 Conclusions Drawn from the Data

This section of the Alabama 1915(b) Independent Assessment Report to be completed following the completion of the Recipient Survey and will be included in the Final Report.

Section 5 Analysis

5.1 Patient 1st Program

5.2 Maternity Care Program

This section of the Alabama 1915(b) Independent Assessment Report to be completed following the completion of the Recipient Survey and will be included in the Final Report.

Section 6 Conclusions and Recommendations

The data obtained in the Alabama 1915(b) Independent Assessment of the Medicaid Agency Managed Care Patient 1st and Maternity Care Programs demonstrates compliance with the provisions of the 1915(b) waiver and improvement in two areas assessed in this report: Access to Care and Quality of Services.

Key Findings for the Patient 1st Program

Using the information gathered, the researchers found the following:

- ☐ The State has an established program of monitoring Patient 1st Quality of Services and Access to Care.
- ☐ The State feels they are behind in monitoring achievements toward programs goals and objectives through provider profiling for the Patient 1st Program due to delays in development of this functionality in the information system. However, they are in the process of developing goals and objectives for new reporting and progress toward this goal is occurring.

Key Findings for the Maternity Care Program

- ☐ The Primary Contractors contracting with the Maternity Care Program are effectively complying with the provisions of the program.
- ☐ The Medicaid Agency has in place an established program and strategy of Quality Assurance and is effectively monitoring Health Plan compliance with the strategy and with contractual requirements.
- ☐ The Maternity Care Program has implemented a program of focused studies to the Performance Improvement Program (PIP).

Recommendations

The Assessors recommendation is that the Alabama Medicaid Agency considers making the following changes:

- ☐ Develop a single internal policies and procedures manual for the Medicaid Agency that documents all policies and procedures with regard to quality improvement, access to care and provider management in the 1915(b) programs.

Appendix A

List of Alabama Medicaid Agency Documents

Patient 1st Documentation

Alabama Administrative Code – Chapter 37
Alabama Medicaid Agency Overall Quality Assurance Plan
- o Quality Assurance Strategy
- o Quality Assurance Unit Policies and Procedures

Medicaid Program Provider Manual Chapter 39
PMP Contracts
REOMB Survey
Patient 1st Quality Assurance Memorandum to the Alabama Medicaid Agency Commissioner
Patient 1st New Enrollee Packet and Recipient Handbook
Profiler Report Sample
H550 Report and H590 Report
Patient 1st QA Stakeholder meeting agendas and minutes
Patient 1st DSS Reports
Patient 1st COLD Reports
Operations Manual
Geographic 24 Hour Audit Schedule
Complaint and Grievance Logs

Maternity Care Documentation

Alabama Administrative Code Chapter 37
Alabama Medicaid Agency Overall Quality Assurance Plan
- o Quality Assurance Strategy
- o Quality Assurance Unit Policies and Procedures

Medicaid Program Provider Manual Chapter 24
Maternity Care Operations Manual
Maternity Care Primary Provider Contracts
District QAPI Plans
District QAPI Committee Minutes
District Complaint and Grievance Logs
Provider Manual
Performance Measure Summaries
Focused Study Results and Summaries
Operations Manual
Primary Provider New Enrollee Packets and Recipient Manuals
Grievance and Appeals Logs

Appendix B

Independent Assessment Core Competency Interview Tool

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Administration							
Quality of Care Quality of Care	Describe strategies and accomplishments achieved in meeting program goals and performance outcome.	1. Do you have documented strategies, goals and performance outcomes for the Patient 1st and Maternity Care Programs?	Patient 1st Performance Strategy Stmt MC Performance Strategy Stmt				a. Yes - Go to question 2. b. No - Stop
Quality of Care		2. Do you measure the progress of the Patient 1st and Maternity Care Programs toward the goals and performance outcomes established in the managed care strategies?					a. Yes - Go to question 3. b. No - Stop
Quality of Care		3. Can you provide documentation of progress by each program toward achievement of the goals and performance outcomes identified in the program strategies?	Patient 1st Summary of Performance Outcomes MC Summary of Performance outcome				
Quality of Care	Describe the use and the effectiveness of the provider profiles in monitoring the achievement of program goals and objectiveness.	4. Do you monitor achievement toward program goals and objectives through a program of provider profiling?					a. Yes - Go to question 5. b. No - Stop

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Quality of Care							
		5. Can you provide documentation to describe the use and the effectiveness of the provider profiles in monitoring the achievement of program goals and objectiveness?	Provider Profile Procedures, Method of Analysis and analysis findings for the Patient 1st Program				
Quality of Care			Profile records for the Patient 1st Program				
Quality of Care			Provider Profile Procedures, Method of Analysis and analysis findings for the Maternity Care Program				
Quality of Care			Profile records for the Maternity Care Program				
Quality of Care	Describe procedures for monitoring providers.	6. Do you have a program for monitoring providers in the Patient 1st and Maternity Care programs?					a. Yes - Go to question 7. b. No - Stop
Quality of Care		7. Can you provide documentation to show what procedures were used to monitor providers?	Monitoring procedures P1st				
Quality of Care			Monitoring procedures MC				
Quality of Care			Provider procedures P1st				
Quality of Care			Provider procedures MC				

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Quality of Care	Describe the results used to determine whether Primary Medical Providers (PMP) meet the terms and conditions and performance agreements of the written contract with the Agency.	8. Can you provide documentation of the results used to determine whether Primary Medical Providers (PMP) meet the terms and conditions and performance agreements of the written contract with the Agency?	PMP Contracts Policies and Procedures for measuring compliance with performance agreements				
Access to Care	Describe procedures used to ensure that a smooth, undisrupted placement/transition occurs for enrollees when the “primary care” provider dis-enrollees from the program or changes practice location.	9. Can you provide documentation of procedures were used to ensure that a smooth, undisrupted placement/transition occurs for enrollees when the "primary care" provider dis-enrollees from the program or changes practice location?	Written enrollment, transition and dis-enrollment procedures P1st				
Access to Care	Describe how “enrollee services date” as addressed in the Patient 1st contract is used as a way to analyze whether a provider is within the Patient 1st comparison parameter.	10. Do you use a method of established comparison parameters for provider comparative analysis?					a. Yes - Go to question 11. b. No - Stop
Quality of Care		11. Can you provide documentation to address how "enrollee services date" as addressed in the Patient 1st contract is used as a way to analyze whether a provider is within the Patient 1st comparison parameter?	Patient 1st Contract				

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Quality of Care			Documentation of Patient 1st provider comparison parameter				
Quality of Care	Describe the “ongoing quality assurance program” and how this procedure is used to evaluate the quality of health care services to enrollees.	12. Can you provide documentation that will address the "on going quality assurance program" and how this procedure is used to evaluate the quality of health care services to enrollees?	Documentation of Quality Assurance Strategy and Policy for the Patient 1st Program				
Quality of Care			Documentation of Quality Assurance Evaluation Procedures				
Quality of Care			Quality Assurance Manuals and Reports				
Quality of Care			Documentation of Quality Assurance Strategy and Policy for the Maternity Care Program		Yes		
Quality of Care			Documentation of Quality Assurance Evaluation Procedures		Yes		
Quality of Care			Quality Assurance Manuals and Reports		Yes		
Enrollee access and receipt of program services							

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Access to Care	Describe procedures or strategies used to monitor/ensure timely access of covered services for new and existing enrollees.	13. Do you have procedures or strategies established to monitor access to covered services by all enrollees?					a. Yes - Go to question 14. b. No - Stop
Access to Care		14. Can you provide documentation of strategies used to monitor/ensure timely access of covered services for new and existing enrollees?	Policies and procedures for monitoring access to covered services				
Access to Care	Describe procedures utilized to ensure providers geographic accessibility for enrollees, especially in rural and remote areas of the State.	15. Do you analyze geographic accessibility to providers with particular emphasis on rural and remote areas of the state?					a. Yes - Go to question 16. b. No - Stop
Access to Care		16. Can you provide documentation of procedures utilized to ensure providers geographic accessibility for enrolls, especially in rural and remote areas of the State?	Geographic breakdown of providers P1st 4.4b				
Access to Care			Geographic breakdown of providers MC 4.4b				
Quality of Care	Describe procedures utilized to follow-up on problems or issues brought to the State's attention by program enrollees or as a result of program monitoring or evaluations.	17. Can you provide documentation of procedures utilized to follow-up on problems or issues brought to the State's attention by program enrollees or as a result of program monitoring or evaluations?	Complaint and grievance procedures P1st				
Quality of Care			Complaint and grievance procedures MC				

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Access to Care	Describe procedures and monitoring results associated with enrollee wait time or hold time for telephone appointments, for provider services, referrals and for subsequent appointments.	18. Do you have standards for and monitor compliance with telephone wait and hold times for appointments, services, and referrals?					a. Yes - Go to question 19. b. No - Stop
Access to Care		19. Can you provide documentation of monitoring procedures and monitoring results associated with enrollee wait time or hold time for telephone, appointments, for provider services, referrals and for subsequent appointments?	Complaint and grievance procedures P1st Complaint and grievance procedures MC				
Access to Care	Describe procedures and monitoring results of providers substantiating that enrollees have 24 hour access to their primary care providers. This should include monitoring results for providers maintaining specified weekly office hours.	20. Do you require Patient 1st providers to provide 24 hour access to primary care providers?					a. Yes - Go to question 21. b. No - Stop
Access to Care		21. Can you provide documentation of policies concerning 24 hour access to primary care providers?	Documentation from Patient 1st Providers concerning procedures to ensure 24 hour access				

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Access to Care		22. Do you monitor provider weekly office hours?					a. Yes - Go to question 23. b. No - Stop
Access to Care		23. Can you provide documentation of monitoring procedures for provider office hours?	Monitoring procedures 24-hr access P1st				
Access to Care	Describe procedures used to ensure that:						
Access to Care	a) new enrollees are assigned to primary care providers within required timeframe;	24. Can you provide documentation of new enrollees' policies concerning assignment to primary care providers within required timeframe?	Doc. Procedures to ensure new enrollees have chosen provider in req. timeframe P1st				
Access to Care	b) enrollees are provided appropriate written information, within reading proficiency levels, for all program services;	25. Can you provide documentation of policies concerning reading proficiency levels for written information provided to enrollees for all program services?	Doc. Procedures - written info w/in reading proficiency levels P1st				
Access to Care			Doc. Procedures - written info w/in reading proficiency levels MC				
Access to Care	c) non-English speaking enrollees have written information appropriate for their nationality or language, and	26. Can you provide documentation of policies concerning written information for non-English speaking enrollees that is appropriate to nationality or language?	Doc. Procedures for providing info to non-English speaking P1st				
Access to Care			Doc. Procedures for providing info to non-English speaking				

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
			MC				
Quality of Care	d) enrollees have the ability to choose their own provider or change their primary care provider without penalties.	27. Can you provide documentation of policies and procedures that ensure the right of the enrollee to choose their own provider or change their primary care provider without penalties?	Doc. Procedures to ensure new enrollees have chosen provider w/o penalty - Patient 1st				
Quality of Care			Doc. Procedures to ensure new enrollees have chosen provider w/o penalty - MC				
Quality of Care	Describe procedures used to monitor direct and or coordinated care services by primary care providers. This should also include arranging for and or providing follow-up of referral services.	28. Do you monitor direct care or coordinated care services provided by primary care providers in the patient 1st program and Maternity Care programs?					a. Yes - Go to question 29. b. No - Stop
Quality of Care		29. Can you provide documentation to describe procedures used to monitor direct and or coordinated care services by primary care providers?	Documentation of policies and procedures used to monitor direct or coordinated care services primary care providers in the Patient 1st program				

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Quality of Care			Documentation of policies and procedures used to monitor direct or coordinated care services primary care providers in the Maternity Care program				
Quality of Care		30. Do policies include arranging for and providing follow-up referral services?	Documentation of policies and procedures for monitoring follow-up and referral services by primary care providers Patient 1st program				
Quality of Care			Documentation of policies and procedures for monitoring follow-up and referral services by primary care providers Maternity Care program				
Access to care	Describe corrective action taken to remedy barriers associated with access to services.	31. Do you have a policy requiring the remedy of barriers to services through corrective action?					a. Yes - Go to question 32. b. No - Stop
Access to Care		32. Can you provide documentation to show what corrective action was taken to remedy barriers associated with access to services?	Policies and Procedures concerning corrective action measures				

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Access to Care			Documentation of complaints against the Patient 1st Program by enrollees alleging barriers to services				
Access to Care			Documentation of Corrective Action taken with regard to service barriers in the Patient 1st Program				
Access to Care			Documentation of complaints against the MC Program by enrollees alleging barriers to services				
Access to Care			Documentation of Corrective Action taken with regard to service barriers in the MC Program				
Provider Network							
Access to Care	Describe procedures for monitoring or ensuring acceptable provider-enrollee ratios.	33 (a). Do you monitor provider-enrollee ratios in the Patient 1st and Maternity Care programs?					a. Yes - Skip question 33(b) and go to 34 b. No - Go to 33(b)
Access to care		33 (b). If not, how do you ensure acceptable provider-enrollee rations in the programs?					a. Yes, Please ask for an explanation of the process, and Go to 34. b. If no method - Stop

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Access to care		34. Can you provide documentation to describe procedures for monitoring or ensuring acceptable provider-enrollee ratios?	Policies and procedures for monitoring and evaluating patient to providers ratios Geographic breakdown of providers P1st 4.4b				
Access to care			Policies and procedures for monitoring and evaluating patient to providers ratios Geographic breakdown of providers MC 4.4b				
Access to care	Describe procedures and outcome results used to monitor or to provide assurances that the total number of primary care providers and specialty providers equal or exceed the total number of providers enrolled in the previous Patient 1st waiver.	35. Do you monitor the levels of primary care and specialty providers enrolled in the Patient 1st program to ensure that they have remained level or have grown since the previous waiver?					a. Yes, Go to question 36. b. No - Stop - Explain

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Access to care							
		36. Can you provide documentation of monitoring procedures and outcome results used to monitor or to provide assurance that the total number of primary care providers and specialty providers equal or exceed the total number of providers enrolled in the previous Patient 1st waiver?	Policies and procedures for monitoring and evaluating patient to providers ratios				
Access to care			Geographic breakdown of providers P1st 4.4b				
Access to care			Documentation of provider-enrollee ratio analysis findings for the Patient 1st Program				
Access to Care	Describe or provide a comparison of the specialists participating in the Patient 1st program with that of the total number of certified specialists in the State by specialty category.	37. Have you conducted an analysis of the specialists participating in the Patient 1st program comparing the number of program specialists with that of the total number of certified specialists in the State by specialty category?					a. Yes - Go to 38 b. No - Stop

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Access to care		38. Can you provide documentation of the comparative analysis methodology used and results of your analysis of the specialists participating in the Patient 1st program with that of the total number of certified specialists in the State by specialty category?	Draft evaluation of provider files (P1st)				
Access to care			Policies and procedures for evaluating patient to specialist ratios (P1st)				
Enrollee Information							
Access to Care	Describe the process used and the results indicating that enrollees' rights are protected and	39. Do you have processes in place to ensure that enrollees' rights are protected?					a. Yes - Go to 40 b. No - Stop
Access to Care		40. Can you provide documentation that shows the process used and the results indicating that enrollees' rights are protected?	Polices and procedures for ensuring Patient 1st enrollee rights and protections				
Access to Care			Polices and procedures for ensuring Maternity Care enrollee rights and protections				
Access to Care	Describe the appeal process is appropriately followed.	41. Do you have procedures to monitor the appeals process and ensure that is appropriately followed?					a. Yes - Go to 42 b. No - Stop

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Access to Care		42. Can you provide documentation of the policies and procedures designed to ensure that the appeal process is appropriately followed?	Policies and procedures concerning Patient 1st enrollee appeals process				
Access to Care			Policies and procedures concerning Maternity Care enrollee appeals process				
Access to Care			Documentation of Patient 1st appeals process tracking mechanisms				
Access to Care			Documentation of Maternity Care appeals process tracking mechanisms				
Access to Care			Written Notice Time Frame Standards				
Access to Care			Resolution and Notification Time Frame Standards				
Access to Care	Describe the process used to monitor established procedures and assurances for enrollee grievances being resolved.	43. Do you monitor enrolled grievances to ensure that all grievances are resolved?					a. Yes - Go to 44 b. No - Stop
Access to Care		44. Can you provide documentation of the procedures used to monitor resolution of enrollee grievances?	Complaint and grievance monitoring procedures P1st				
Access to Care			Resolution and Notification Time Frame Standards				

Core Area	CMS Required Assessment Criteria	Questions	Documentation	Documentation Location	Received Documentation	Compliance Result	Response
Access to Care			Complaint and grievance monitoring procedures MC				
Access to Care			Resolution and Notification Time Frame Standards				

Appendix C

Recipient Survey Tool

This Appendix will be completed upon completion of the Recipient Survey for the final draft of this report.